Declination Form

Name:_____
Social Security Number:_____
Title:_____
Signature:_____

Refusal of Recommended Treatment

I have been given information concerning the treatment recommended by_____and have had the opportunity to ask any questions that I may have, however, I decline treatment at this time. I understand that I may be at risk of acquiring complications, disease and / or infection.

Date:_____
Signature:_____
Witness:_____